THE EYE SITE
IN COPLEY

Federal regulations require that we confirm the identity of patients using insurance with a photo ID.
To help speed the processing of your claims, please allow us to make a copy of your insurance cards.

Name _____ **Today's Date**_____/_____/_____
Last First MI

Address: _____
Street Apt City State Zip

Preferred Name (Nickname):_____ **Sex**: Male ☐ Female ☐
(for insurance purposes)

Date of birth _____/_____/_____ **SSN** _____-_____-_____

Home phone: _____ **Cell phone:** _____

Email Address:_____

Your Employer (or school) _____

Primary **Medical** Insurance: _____ Policy #/ID: _____

Primary **Vision** Insurance: _____ Policy #/ID: _____

If you are not the policy holder, please list the policy holder's full name and DOB, and address, and SS#:

Name:_____DOB: _____/_____/_____

Address: _____ SS#:_____

Reason for today's visit (check all that apply):

☐ Need new glasses
☐ Need more contact lenses
☐ Blurred vision with current prescription
☐ Eye discomfort
☐ Annual Exam
☐ Other _____

Assignment, Release, and Acknowledgement

I authorize payments of benefits directly to The Eye Site for services rendered. I also authorize release of any medical information that may be required in determination of such benefits. I understand some services may require approval of my primary care physician for coverage and that if I do not obtain that approval I am financially liable for the services. I understand that my insurance carrier(s) may not cover some services and products and benefit information does not constitute approval for payment. Deductibles and fees not paid by my insurance carrier will be my responsibility.

Signature of patient (or legal guardian) _____

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Have you been diagnosed with any eye conditions or diseases? ☐ yes ☐ no. If yes, please list.

_____

Do you have, or take medication for any of the following? Please check all that apply.

☐ Ear/nose/throat problems	☐ Heart disease	☐ Skin disorders
☐ Sinus congestion	☐ High cholesterol	☐ Diabetes
☐ Serious headaches	☐ Artery disease	☐ Thyroid disease
☐ Neurologic condition	☐ Asthma or COPD	☐ Blood disorder
☐ Anxiety/depression	☐ Stomach problems	☐ Seasonal allergies
☐ High blood pressure	☐ Urinary problems	☐ Cancer

Please list all medications you take, including eye drops _____

_____

_____

Are you allergic to any medications? ☐ yes ☐ no…If yes, please list: _____

_____

Have you had any type of **eye surgery**? ☐ yes ☐ no
If yes, what surgery? _____

Alcohol consumption (check one): ☐ yes ☐ no ☐ occasional

Smoking status (check one): ☐ no use ☐ daily ☐ occasional ☐ previous smoker

Is there a history in your **family (parents, siblings, or children)** of any of the following? Check all that apply.

	Father	Mother	Brother	Sister	Son	Daughter
Diabetes	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Retinal Detachment	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Blindness	☐	☐	☐	☐	☐	☐

Do you currently wear glasses? ☐ yes ☐ no **Do you wear contact lenses?** ☐ yes ☐ no

If you wear contact lenses, what is the brand? _____

Name/address of your primary care physician: _____